SWVTC RCSC OUTPATIENT REFERRAL REQUEST

SECTION I: **Case Manager to complete*:* Please complete ALL items putting N/A where applicable.**

CLIENT NAME:_____ SS #: _____
(FIRST) (MIDDLE) (LAST)

CLIENT ADDRESS: _____
Number/Street or P.0. Box

_____
City/Town State Zip Code Phone

BIRTH DATE_____ AGE:_____ SEX: M F (circle) MR Level (circle) Profound Severe Moderate Mild

CSB:_____ CASE MANAGER:_____ PHONE _____

RESIDENTIAL PROVIDER: _____CONTACT _____PHONE _____

EMERGENCY
CONTACT_____PHONE_____

IMMEDIATE FAMILY MEMBER _____

ADDRESS_____ PHONE _____

Number/Street or P.O. Box City State Zip Code

VOC PROVIDER: _____CONTACT:_____PHONE _____

BEHAVIOR PROGRAM SPECIALIST:_____ PHONE_____

SERVICES REQUESTED:
_____
_____
_____

CLIENT INFORMATION:

MEDICAL DIAGNOSIS:_____
_____

PRESCRIBED MEDICATION: _____
_____

CAPABILITIES: (CIRCLE THOSE THAT APPLY)

a. Ambulatory: Yes No Use: Wheelchair Walker Other

b. Communication: Non-verbal Gestures Manual Signing Vocalizations Verbal

c. Sensory Impairments: Partially Deaf Deaf Partially Blind Blind

d. ADL"s: Total staff assistance Mostly staff assistance Minimal staff assistance Independent

COMPLETED BY**:**_____ Date:

CSB COORDINATOR:_____ Date:

When completed Fax to: SWVTC at (276) 728-1103; Attention: Karen Poe, RCSC Referral

SECTION II: SWVTC STAFF TO COMPLETE:

Date Referral Received:_____ Former RCSC Client? Y or N Former SWVTC Resident? Y or N

Presenting Problem:

Reason for Referral:

History:

Behavioral issues:

Psychiatric issues:

COMPLETED BY:_____ Date:

SECTION III

Forms Required (check all that apply)	Date Received
Patient Registration Consent	
Current Physical	
Consent for Medical/Surgical Or Dental Treatment	
Consent to Exchange Info	
Medical Hx Questionnaire	
Psychiatric Report	
Physician Order (PT only)	

SECTION IV

1)Referred to:_____ What Service:

2)Comments:

3)Reason Why Services Not Provided:

COMPLETED BY:_____ Date:

SECTION V

Follow-up on dental services:

Call made to ensure no new medical problems have occurred in the last five days before the scheduled appointment.
Name of person spoken with about the patient and relationship to the patient.

_____

COMPLETED BY:_____ Date: